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ABSTRACT

Community mental health center services must be most plentiful where the need is greatest and must be appropriate and available to meet these needs. The first high priority group, according to statistics on juvenile delinquency, and narcotics, is the black inner city. Socio-psychiatric services, numerous enough in quantity to begin to meet needs and specific enough in character must be developed. The individual himself will receive high priority. However, high priority must also be assigned the family, informal and formal groups, and groups in conflict. A third priority of concern is not only with the role of the patient or with the sickness in an individual, but with the well behavior of the designated patient. Fourthly, there are those with special needs growing out of the nature of their life experiences, the criminal, social deviants, and mentally retarded. The next high priority is for those who lack essential services (the poor), the children and youth, and the elderly. The sixth group high in priority is those persons who occupy a negative imposed social position such as ethnic minorities. The two final target groups are: (1) the minority of white men in positions of real power, (2) the vast majority of white men who have power ascribed to them simply by virtue of their being white. (KJ)

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# OBLIGATIONS TO HIGH PRIORITY TARGET GROUPS: PHILOSOPHICAL IMPLICATIONS*

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# OBLIGATIONS TO HIGH PRIORITY TARGET GROUPS:

# PHILOSOPHICAL IMPLICATIONS

Any determination of obligations to high priority target groups is dependent upon several interrelated factors--the vantage point from which the determination is made, the hierarchy of interests and values held by those making the determination and the inclusiveness or exclusiveness of the groups to whom an order of priorities is assigned. Equally as important may be the philosophical frame of reference, for this determines the designation of the goal, prescribes the steps to reach it, and defines the operational context of such terms as community, mental health and center.

Thus, agencies or policy makers holding clinical, social, or socio-psychiatric orientations will each define differently the word "community"--as patients and helpers, as an organization of social beings, or in terms that combine the clinical and social systems approaches. They will consider different classes of phenomena as relevant to the functions of a community mental health center. They will view a center as a structural entity, as a base for varied operations or as one element in interacting systems of individuals, social groups and institutions. They will each hold implicit views that, at their most extreme, differ greatly from those held by persons operating from a psychoanalytical orientation or one which is socio-economic, economic or any one of several other orientations.

The limitations imposed by holding fast and unquestioningly to a philosophical framework or to the model developed from it have been made painfully evident in the fields of mental health, education and social welfare. Here, these limitations have characteristically resulted in restrictiveness and rigidity. The clinical model of cure, the ineffectiveness of middle-class educational techniques for inner-city public school students, and the malevolent dehumanization of the

welfare system are indicators of the failure to consider the interaction of human beings and their social environment in the development of services.

What are the significant aspects of this social environment today, both cause and effect of changes in the conditions of life? Increasing technology, automation and concern with things rather than with people escape into drugs, work or the box; generational gaps, anomie and alienation; mounting dependency, unemployment and poverty in the midst of affluence; an imbalance in the allocation, distribution and availability of human services; an ever increasing expendability of individuals, on the battlefield, on the ghetto streets, in the job market; and a nation which indicates clearly that it places a higher value on claiming the unknown terrain of the moon than on rediscovering the cleanliness of air on earth, a higher value on fighting the specter of communism than on destroying the monster of white racism at home.

I speak from the vantage point--personal and professional--of a woman, a wife and mother, a black American; raised in moderate comfort, educated in a liberal arts college which took equal pride in its high degree of exclusiveness and its high academic standards; trained and experienced as a psychiatrist, psychoanalyst and group therapist; a member of the comfortable upper-middle class whose interests are often far removed from those of high priority-need groups.

I speak from the vantage point to which growth and change have brought me--that of a physician concerned with public health, aware that the highest admission rates to state psychiatric hospitals are those of the black inner cities; that of a member of the black community, deeply disturbed by the poverty, discrimination and powerlessness that interfere with emotional health and physical health; that of a social psychiatrist whose efforts in rehabilitation vividly illustrate the complex nature of the relationship between man and his environment.

I place high value on human life and on those conditions of living which en-

hance the development of individual and group potential, not for the few but for the many, not for the strongest alone but for the weakest, the poorest, the most deprived.

The operational frame of reference consistent with this humanistic orientation is a socio-psychiatric one which considers behavior to have multiple interrelated determinants, intrapsychic,interpersonal, social. Human services--including mental health services--are conceived and developed which recognized the potential effectiveness of the interplay between broad social forces and the technical contributions of mental health and social science professions. Significant elements of such programs encompass and integrate which has been shown to be distinctly therapeutic with the immediate and pressing concerns of persons whose environments have heretofore offered little basis for hope, trust or control of their own destinies.

In this context personal and professional behaviors are encouraged which are relevant to social and psychiatric development and contributory to the enrichment of human life, both for those designated as the helpers and as the helped.

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The first high priority group, seen from this viewpoint, is that in the greatest need of psychiatric services. Admission rates to state psychiatric hospitals from Central Harlem are the highest in the City, a situation typical of large urban centers. The need is thus evident for massive allocations of mental health services to this and similar communities for those suffering from acute and chronic psychiatric illness.

In addition, several related statistics can be cited as illustrative of the black inner city. In New York City, Central Harlem has the highest statistical incidence of sub-standard housing, unemployment, narcotics, addiction, public assistance, juvenile delinquency, veneral disease, and failure to complete high school. It also ranks lowest in per capita income for the City as a whole. If planners of

mental health services were to concentrate their efforts solely on meeting the greatest psychiatric needs,this area and others close approaching it in similar slum ghettos would of necessity receive maximum psychiatric funds and resources. In order to do so effectively, providers of psychiatric service would be forced to take into account in limited or extensive ways the other conditions of life besides mental illness which may contribute to its cause, deter recovery, and thwart efforts at developing positive mental health. This implies the development of socio-psychiatric services, numerous enough in quantity to begin to meet needs, specific enough in character to prove effective.

Second, this view holds that the individual is not the sole target of mental health concern. The individual person receives high priority indeed. But high priority is also assigned the family, informal and formal social groups, groups in conflict, evidencing the maladaptive behaviors of race hatred, self-aggression, aggression towards others, self-defeating or anti-social behavior. From this viewpoint grows an emphasis upon group services which mobilize cooperative and democratic, rather than the authoritarian processes.

Multiple and appropriate group services are developed which range in depth from the supportive to the analytic and in goals from the solution of problems to education, insight, change in behavior or personality reorganization.

Such psycho-social processes not only increase communication, and aid the exploration of individual reactions and the resolution of inner conflicts but allow knowledge to be gained and applied, coping behaviors to be learned, and the concept of causality to be dealt with in such a way as to lead to increased responsibility as well as inner change. Although it is not the primary aim of therapeutic and educational groups to promote social action, such group approaches in deprived communities can lend from unproductive individual isolation to more successful action with the group and through the group. For some, this may prove a model for

autonomous social action designed to affect the determinants of deprivation.

A third priority of concern is not only with the role of the patient or with the sickness in an individual, but with the well behaviors of the designated patient. There is a lack of knowledge in the field of psychiatry concerning the course of recovery from mental illness and the restitutive forces that exist outside of the hospital, physician's office or treatment program. IN this orientation, emphasis is placed upon acquiring and applying knowledge of mental health as well as mental disorder, of personality development as well as disturbance, of factors with latent adaptational potential not previously known to psychiatry, restricted by a pattern of concentration on illness as the problem and cure as its goal. Basic research and action research can both contribute to this knowledge, along with a potential wealth of clinical observations, clinical impressions have too often been left unread and unevaluated in case records or, at the other extreme, used as a basis for extrapolation from the individual patient to human beings in general. Such studies, taking into account social and psychiatric variables, may lead to the planned application of knowledge to service.

The sociopsychiatric viewpoint holds, fourth, that there are those with special needs growing out of the nature of their life experiences. Persons who have been labeled as chronically ill, as socially deviant, as mentally retarded, as criminal, for example, require concerted and specialized attention in mental health center programs. Yet the contrary would seem to be in store. The highest priority and greatest value have been placed by program planners on services to those persons whose illnesses can repond to the type of treatment valued the most, the troubled neurotic persons are "good psychotherapeutic risks". Few centers have given the emphasis in their programs to persons in need of continuing care, to drug addicts, to mentally retarded people. Rehabilitation--psychiatric, social, vocational--is still considered a second-rate modality, perhaps not even in the realm of psychiatric

services. Socio-psychiatric and socio-educational interventions are still considered second-class services for people with second-class problems. Unless some effort is made to alter this hierarchy of values assigned therapeutic modalities and to develop and value services appropriate and effective in meeting the needs of the less glamorous patients and clients, community mental health centers will be merely old psychiatric clinics and hospitals under new names, contributing to a dual system of the delivery of psychiatric services rather than effectively meeting needs with high quality staff and interventions.

Fifth, high priority is assigned those who have not--those who lack essential goods and services (who make up the increasing numbers of poor people), those who are in need of developing skills by which to become productive members of society (children and youth), and those whose years of possible productivity have passed (the elderly). The deprivation of poverty, the struggle towards growth of children and youth and the overwhelming uselessness of old age can be borne with submissiveness and passivity or with assertive success. In this orientation, psychiatry attempts to develop the potential within each individual through collaborative efforts with others, social scientists, educators, industry. In broadening its concept of the team, psychiatry can define its unique elements, work more productively on complex issues, and develop a relatedness to the totality of human behavior.

Working together, behavioral scientists can enrich the roles each could play alone, particularly in the direction of developing preventive interventions: for idle, poorly-nourished, ill-educated youth soon grow old with their children and their children's children contributing to the social good or being defeated by dependency, themselves, and the world around them.

There is a sixth group high in priority, those persons who occupy a negative imposed social position. Denied the opportunity to develop individual and group

potential by the restrictive, devalued imposed social position they hold, such groups include members of ethnic minorities--black Americans, Puerto Ricans, Indiams, Mexican-Americans; persons born in certain sections of the country--the insulated rural areas or the urban slums; persons born outside the social system of acceptability. Greater quantities of mental health services in the traditional mold will be of diminished effectiveness unless means are found to articulate these individuals and groups into meaningful roles in a society in which they have been powerless. The path towards articulation may be through essential stages of group solidarity and group identity leading ultimately to group power before full participation can take place as equals in value if not in number. Such phenomena as negritude, black power, and black consciousness and the new coalitions across color lines represented by the Poor People's Campaign and welfare rights groups illustrate social phenomena which have their effects not only upon intragroup and intergroup relations, but upon the personality development and the identity of the young of today.

The exploration of possible routes towards separatism or articulation, the intervening processes and the influence of social phenomena upon individual personality dynamics all fall within the concern of the mental health professions and warrant greater emphasis. Non-articulation has negative effects upon individuals and groups--both the insiders and the outsiders--which can no longer be overlooked by psychiatry merely because they are not completely understood.

Underlying all other priorities is that afforded the member of the community--not separate from the other groups referred to--high in priority from three points of view: as a consumer of services, as a participant in planning, control and in decision-making services, and as a provider of services.

The need for the appropiateness, availability, usefulness and coordination of mental health services, within the framework of continuity of care does not have to

be spelled out. It is a need which consumers of mental health services voice vehemently. In this regard, both policymakers and consumers are in general agreement. They differ, however, on how this need is to be met and on the specific characteristics of service.

An even greater difference emerges when the community member moves from the role of consumer to an attempted role as participant. The requirement for maximum feasible participation by the consumer has led to deception, buying off of community leaders and tokenism. Indeed, the very concept of "maximum feasibility" indicates clearly that the limits of participant power are to be determined by the interests of those traditionally in power. Efforts are being made on several levels to change this balance of power. The demand for real decision-making and for community control rather than absentee landlord control must lead to a struggle (whether the landlord is the rich university on the hill overlooking the ghetto, the benevolent philanthropist in the suburbs or the wily politicians downtown).

But the struggle will not be without benefits. The desire to participate on all levels as persons providing services--professional and nonprofessional, administrative and service, managerial and fiscal, technical and executive--could ultimately contribute to the resolution of a manpower shortage in human services, as well as to a larger change in the seat and structure of power. The manpower change alone will require and ultimately bring about modifications in the accrediting criteria, in the access to technical and professional institutions, in the acceptance of the educational value of life experiences, and in the mental health and educational systems themselves--in short, in institutional change. At each level, psychiatrists have a role to play, rather than leaving the struggle to administrators and community representatives alone. It is to participate in planned change.

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Thus, I maintain that community mental health center services must be most plentiful where the need is greatest and must be appropriate and available to meet

these needs. There must be variety in organization, structure and function. There must be a range from treatment to re-education, from concern with goods and services to concern with potentiality for entry into positions of power and self-determination, from institutional change to social change.

This change in the social context can come about through plan or through happenstance, through development or through last-ditch concessions. The choice will be dependent to some degree upon how soon those of us in any positions of influence in the mental health field are able to realize that the field itself is altered by social forces, and with this recognition, are able to move actively rather than be moved passively by the changes of time.

This leads to two final target groups to whom attention must be paid by you who listen to me. Today, almost one month after the murder of Martin Luther King by white American racism, these groups require urgent attention. They are the minority of white men in positions of real power--governmental, industrial, professional, economic, military, political, educational power--and the vast majority of white men who have power ascribed to them simply by virtue of their being white. They--and the part of them that is you--must be spoken to--by you. They must be reached--by you. They must be forced to face themselves and to see the damaging effects of racism on their lives--your lives. They must be aided to alter their behavior if not their attitudes--now--before it is too late.

You cannot wait--we cannot wait--until psychiatry joins other behavioral sciences in defining techniques for developing democratic behaviors in young children, though is is a sure and a certain need. You cannot wait-we cannot wait--until individual and group experiences at undergoing therapeutic re-education have been attempted or until concessions have been granted a few to placate the many, or until a greater crisis develops to divert our attention, efforts and priorities. You must not wait until the violence of four hundred years to Americans of color has been

matched by black men's finally turning their aggression away from themselves to their white oppressors--all white men; the resulting repressive measures would insure the death of whatever we have managed to preach, if not practice, of democracy.

This nation is at a point of crisis--not merely a crisis in funds or services or values--but a crisis in human relations, that with which psychiatrists ought to be most closely concerned. If there is any relevance which psychiatry can have to this day, it is to concern itself not only with the individual who is sick, but with the sickness of white racism in society. There is sickness in the fabric of this society. Yet to view white racism only as a sickness can lead to an oversimplification which can be mis-used to deny its less dramatic manifestations in one's self with righteous claims of health, purity and good intentions. It is too easy for psychiatrists, in particular, to interpret this point of view as a mandate to treat "the sick racist, the others". But racist behavior, mores and laws are institutionalixed, sanctioned and systematically reinforced in this country. Racism is a significant feature of American life, with manifold overt and latent effects on white and black, participant and recipient, those who tacitly approve and those who passively accept. Racism is a social force which influences and affects individual personality development and mental health as it affects and influences the more obvious social behavior of men. Racism is a negative social force which must not only be understood but eliminated.

As the burden of responsibility for positive change away from racism within this society lies more heavily with the dominant majority, the white majority, so does the potential for using power for the common good, for the development of human resources and for the realization of individual potential and dignity.

As psychiatrists, as citizens, as human beings, there is a responsibility, a need, an imperative for you to act so that the white majority will change, so that you will change, the imperative exists to direct priorities, services and individ-

ual and group efforts toward change within these two seats of power to eliminate the racist behavior in institutions and in individuals in the white community.

It begins with self-examination and acts of personal responsibility; it moves from the family, social groups and neighborhood to the profession of medicine, psychiatry, the mental health field, and to the political, economic and social institutions beyond, emerging from self-interest in the face of crisis at the least, or from a belief in man's right to develop his humanity, it requires a commitment to change, to the change that is growth and life for the individual, black and white, healthy and ill, strong and weak, toward the social change that can be growth and life for us all.

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5/20/68